



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Memorial Compounding Pharmacy

Respondent Name

Ace American Insurance Co

MFDR Tracking Number

M4-18-0527-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

October 30, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has received the attached bill and has not processed according to Texas Labor Code 408.027."

Amount in Dispute: \$178.78

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment has been denied. Our utilization review department found the medications were not medically necessary."

Response Submitted by: Broadspire, P.O. Box 14351, Lexington, KY 40512-4351

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 12, 2017	Tramadol HCL 50 mg Gabapentin 300 mg	\$178.78	\$87.72

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
- 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
- 28 Texas Administrative Code §134.530 sets out the closed formulary requirements for claims not subject to certified networks.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 39 – Denied – Services denied at the time authorization/precertification was requested

Issues

1. Did Broadspire raise a new defense pursuant to 28 Texas Administrative Code §133.307?
2. Is Broadspire's reason for denial of payment supported?
3. Is Memorial Compounding Pharmacy entitled to reimbursement for the compound in question?

Findings

1. In its position statement, Broadspire argued on behalf of Ace American Insurance Co, "Our utilization review department found the medications were not medically necessary."

28 Texas Administrative Code §133.307(d)(2)(F) states, in relevant part, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

Review of the submitted documentation finds that Broadspire failed to present a medical necessity denial to Memorial Compounding Pharmacy in accordance with 28 Texas Administrative Code §133.240 prior to the date the request for medical fee dispute resolution (MFDR) was filed. The division concludes that this defense presented in Broadspire's position statement shall not be considered for review because this assertion constitutes a new defense pursuant to 28 Texas Administrative Code §133.307(d)(2)(F).

2. Memorial Compounding Pharmacy is seeking reimbursement of \$178.78 for medication dispensed on May 12, 2017. Broadspire denied the disputed claim with adjustment reason code 39 – "Denied – Services denied at the time authorization/recertification was requested."

28 Texas Administrative Code §134.530(b)(2) states that in pertinent part, preauthorization is **only** required for:

- drugs identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary*, and any updates;

The division finds that the medication in question is not identified with a status of "N" in the current edition of the ODG, *Appendix A*. Broadspire failed to articulate any arguments to support its denial for preauthorization. Therefore, the division concludes that the medication in question did not require preauthorization and Memorial Compounding Pharmacy's denial of payment for this reason is not supported. Therefore, the disputed medication will be reviewed for reimbursement.

3. 28 Texas Administrative Code §134.503 applies to the compounds in dispute and states, in pertinent part:

(c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:

(1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:

(A) Generic drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;

(B) Brand name drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.09) + \4.00 dispensing fee per prescription = reimbursement amount;

The fee calculation of the services in dispute is below;

Medication	NDC & Type	Price/ Unit	Total Units	AWP Formula §134.503(c)(1)	Billed Amt §134.503 (c)(2)	Lesser of (c)(1) and (c)(2)
Tramadol HCL 50 mg	57664037718 Generic	\$0.795615	30	\$33.86	\$81.39	\$33.86
Gabapentin 300 mg	45963055650 Generic	\$1.32960	30	\$53.86	\$97.39	\$53.86
					Total	\$87.72

The total reimbursement is \$87.72. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$87.72.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$87.72, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____	Peggy Miller	December 19, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.